DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445373 B. WING NAME OF PROVIDER OR SUPPLIER 06/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C 202 EAST MTCS ROAD MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 A recertification survey and complaint investigation #33762 and #33900, were completed at Northside Health Care Nursing and F-270 Rehabilitation Center on June 23 - 25, 2014. No 483.20(d), 483.20(k)(1) deficiences were cited related to complaint investigation #33762 and #33900, under 42 CFR DEVELOP COMPREHENSIVE Part 483, Requirements for Long Term Care CARE PLANS Facilities. F 279 483.20(d), 483.20(k)(1) DEVELOP F 279 Requirement: SS=D | COMPREHENSIVE CARE PLANS The facility must use the results of A facility must use the results of the assessment the assessment to develop, review to develop, review and revise the resident's and revise the resident's comprehensive plan of care. comprehensive plan of care. The facility must develop a comprehensive care The facility must develop a plan for each resident that includes measurable comprehensive care plan for each objectives and timetables to meet a resident's resident that includes measurable medical, nursing, and mental and psychosocial objectives and timetables to meet a needs that are identified in the comprehensive resident's medical, nursing, and assessment. mental and psychosocial needs that are identified in the comprehensive The care plan must describe the services that are assessment. to be furnished to attain or maintain the resident's highest practicable physical, mental, and The care plan must describe the psychosocial well-being as required under services that are to be furnished to §483.25; and any services that would otherwise attain or maintain the resident's be required under §483.25 but are not provided highest practicable physical, due to the resident's exercise of rights under mental, and psychosocial well-§483.10, including the right to refuse treatment being as required under #483.25; under §483.10(b)(4). and any services that would otherwise be required under #483.25 but are not provided due This REQUIREMENT is not met as evidenced to the resident's exercise of rights under #483.10, including the right Based on medical record review, facility hospice to refuse treatment under agreement review, and interview, the facility failed #483.10(b)(4). LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Sministrator Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/02/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445373 B. WING NAME OF PROVIDER OR SUPPLIER 06/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C 202 EAST MTCS ROAD MURFREESBORO, TN 37130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 1 F 279 Corrective Action: to ensure a Hospice Plan of Care was in place for one resident (#23) of seven Hospice residents 1. On 6/25/14, the Hospice Agency reviewed of thirty-one residents reviewed. faxed the facility a copy of the Hospice Plan of Care and the DON The findings included: placed in the resident's Hospice Chart and electronically scanned Resident #23 was admitted to the facility on into their Electronic Medical January 3, 2014, with diagnoses including Record (EMR) to ensure the Depressive Disorder, Generalized Anxiety, nursing staff have the appropriate Cerebral Vascular Accident, Congestive Heart access. Failure, Aphasia, and Hypertension. 2. On 6/25/14, the DON, ADON, Medical record review of a Physician's order and Regional Nurse Consultant dated January 8, 2014, revealed an order for a conducted an audit to ensure all Hospice consult. Continued review revealed an hospice resident's had a Hospice order dated January 12, 2014, to admit to Plan of Care in their Hospice Chart Hospice services. and in the EMR to ensure access Review of the Facility and Hospice Agreement by nursing staff. dated October 28, 2013, revealed, "...HOSPICE shall develop and maintain a written Hospice Plan On 6/25/14 the DON and of Care. The Hospice Plan of Care will identify Staffing Coordinator conducted an which provider is responsible for performing the in-service with the MDS respective functions that have been agreed upon Coordinator and the nursing staff and included in the Hospice Plan of Care..." stating that all Hospice residents must have their Hospice Plan of Interview with the Regional Nurse Consultant at the nurse's station on June 25, 2014, at 10:00 Care in the EMR for access by a.m., confirmed the facility had failed to ensure a nursing staff. hospice plan of care was developed. F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET 4. The DON and/or other designee F 281 SS=D PROFESSIONAL STANDARDS will review all new Hospice residents upon admission for The services provided or arranged by the facility appropriate documentation x 60 must meet professional standards of quality. days and will report their findings to the quarterly QA&A 07/31/14 This REQUIREMENT is not met as evidenced Committee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/02/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BULDING_ COMPLETED 445373 B. WING NAME OF PROVIDER OR SUPPLIER 06/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C 202 EAST MTCS ROAD MURFREESBORO, TN 37130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) F 281 Continued From page 2 F 281 F-281 Based on medical record review, facility provided SS=D instructions, observation, and interview, the 483.20(k)(3)(i) facility failed to administer an inhaler per facility SERVICES PROVIDED MEET policy and instructions for one (#96) of five PROFESSIONAL STANDARDS residents reviewed for medication administration. Requirement: The findings included: The services provided or arranged by the facility must meet Resident #96 was admitted to the facility on May professional standards of quality. 19, 2014, with diagnoses including Diabetes Mellitus, Anemia, Hypertension, and Pneumonia. Corrective Action: Medical record review of the Minimum Data Set dated May 26, 2014, revealed the resident had a 1. (a) On 6/25/14, Nurse # 1 was Brief Interview for Mental Status score of 9 which immediately inserviced by the indicates the resident has some moderate DON on medication cognitive impairment. Continued medical record administration. (b) The DON review of the Physician's Recapitulation Orders placed medication administration for June 2014 revealed, "...Flovent (type of guidelines for inhalers in three ring corticosteroid inhaler)...two puffs two times binders on all med carts. daily..." 2. The DON conducted visual Observation of Licensed Practical Nurse (LPN) audits to ensure that other residents #1 in the resident's room on June 24, 2014, at received medications as ordered by 7:37 a.m., revealed LPN #1 administered the the Physician, Flovent inhaler to the resident and failed to give instruction to the resident for inhaler use prior to 3. The Staffing Coordinator administration. Continued observation revealed conducted inservice training on the resident took two consecutive puffs, without 6/25/14 for all licensed nursing waiting between puffs and handed the inhaler staff regarding the appropriate back to the LPN. Further observation revealed procedures for administering the LPN failed to have the resident rinse the inhalers and that medication mouth after use. administration guidelines for inhalers were placed in binders on Review of facility policy, Inhaler Administration, all med carts for review. revealed, "...8. Explain procedure to resident...14. Ask resident to breathe out...16. Press down on inhaler once to release medication as resident

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF		445373	B. WING_				
	SUMMARY STAT	URSING AND REHABILITATION EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	IC ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON	06/25/2014	
F 309 4 SS=D H En proor made and The by: Backet the price	starts to breathe in sil 3-5 seconds17. Rebreath18. If another different medication is minutes19. For ster resident with cup of wrinse the mouth and silnterview with LPN #1 June 24, 2014, at 8:28 did not follow facility prediministration. Interview with the Direct he DON's office on Justin and the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility has been sold to be a silder of the facility	cowly through the mouth over esident should hold resident should hold resident should hold resident should hold required, wait 1-2 oid inhalers, provide reter and instruct him/her to pit water back into cup" The at the nurse's desk, on a sa.m., confirmed the LPN olicy for inhaler at of alled to follow the administration. E/SERVICES FOR Seive and the facility must have and services to attain practicable physical, all well-being, in apprehensive assessment not met as evidenced of review, review of the provide services was provided for one (#46) of one	F 309	4. The DON, ADON, Staffing Coordinator, and/or other designee will conduct weekly medication pass audits x 30 days and randomly thereafter to ensure licensed nursing staff adhere to the medication administration guidelines for inhalers and will report their findings to the quarterly QA&A Committee. F-309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Requirement: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.		07/31/14	

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STATEME	・いうしょ ひたたいんにいいにん	(X1) PROVIDER/SUPPLIER/CLIA					FORM APPROV OMB NO. 0938-03	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	^	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	(X3)	DATE SURVEY COMPLETED	
NAME O	F PROVIDER OR SUPPLIER	445373	_ [.	B. WING	 _	- 1		
					STREET ADDRESS, CITY, STATE, ZIP CO		08/25/2014	
NORTH	ISIDE HEALTH CARE N	URSING AND REHABILITA	TION C		202 EAST MTCS ROAD	DE		
				Í	MURFREESBORO, TN 37130			
(X4) ID PREFIX TAG	TOTAL DEPRESENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF CORR	20145	(X5) COMPLETION DATE	
F 309	Continued From page The findings included	!:		F 30	Corrective Action:			
1	Resident #46 was adr	mitted to the facility on	Ì		1. (a) On 6/25/14, the facility		1 1	
ļ	Trovernoer 6, 2012, W	ith diannoses includies			obtained documentation from the	te	 	
!	CONGESTIVE HEAR PAR	IIIO End Stock Done)			Dialysis Clinic for the missing			
}	Disease, and Atrial Fit	orillation.	-		dates for resident #46 and (b) th	p.	1 1	
- 1	Medical record review	of the tree ones	1		DON placed missing	1	1	
	Physician Recapitulation	OF THE JUNE 2014	1		documentation in Dialysis hinde	_	- 1	
	uidiyələ as schedille.	C. three times wentle . It	-		and scanned into the EMR.	` [j	
; ,	JONION OF ISCHILL COUNT	Millication forms and	- 1		}	- 1	1	
j #1	ivioiily ducumentation	TOYON ON TO	ĺ		2. Resident #46 is currently the	- 1	- 1	
l b	ocumentation of the co	ondition of the patient	1		only resident at the facility	1	1	
, 2	CICLE CIGIVEIS BUILDING	D Potuto for the fallend	1	j	receiving dialysis.	1	ĺ	
5.	8, 12, and 26, 2014.	3, 6, 22, and 27, April 3,			3 On 6/25/14 A. D. C.	- 1	1	
1			1	1	 On 6/25/14, the Staffing Coordinator inserviced all licensed 	1	- 1	
R	eview of facility policy,	Dialysis Patient Services,		1	nursing staff on proper pre and	1	- 1	
,,~	TOUCOO. COMMINING	CATION is proposited to the	j	1	post dialysis procedures and	1	1	
,	re of a dialysis patient. cumentation required:	5 Nuccino	1		documentation and on obtaining	1	- 1	
be	fore dialysis and upon	return "	İ	- 1	the appropriate documentation	1		
i i			}		upon resident's return from	- 1	- 1	
Inte	erview with the Directo	r of Nursing (DON) on			dialysis. Nursing staff were also	}	1	
9 (4)	** **, *** 14. di 0:07 2 1	M IN the DONE Co			inserviced on if residents return	1	1	
1001	איני עונטען אווט ואכווודע אארי	tailed to recuire the			from dialysis without the	}	1	
dial	essary care and services.	ces prior to and after			documentation, the nursing staff	1		
12 483	2.25(a)(3) ADL CARE F	DOMOTO FOR		- }	are to contact the Dialysis Clinic	- 1	ł	
=D DEF	PENDENT RESIDENT	S LOAIDED FOR	F:	312∫	and obtain the information for the]	[
				İ	EMR. A Dialysis binder was			
A re	sident who is unable to	carry out activities of			placed at the nurses' station to			
) vany	riving receives the ne	CASSADY SONTOON to			maintain all dialysis		- 1	
1 11101	ntain good nutrition, gro oral hygiene.	poming, and personal			documentation and			
4110	via nygione.			1	communication.		j	
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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	4500 4 11	·	OMB NO. 0938-
		IDENTIFICATION NUMBER:	A. BUIL	ALTIPLE CONSTRUCTION DING	(X3) DATE SURVE COMPLETED
	F PROVIDER OR SUPPLIER	445373 URSING AND REHABILITATIO	B. WING	STREET ADDRESS, CITY, STATE, ZIP C	06/25/201/ ODE
(X4) ID PREFIX TAG	SUMMARY STAT	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE A	PHO) 10 PP 1747
In Co. Section 1 de la contra del contra de la contra del la contra de la contra de la contra del la	Congestive Heart Fail Disease, and Atrial Fil Disease, and Atrial Fil Medical record review Physician Recapitulation. It was a schedule Review of facility commursing documentation of the coefore dialysis and upoplates: June 12, May 1, 5, 8, 12, and 26, 2014. Review of facility policy, evealed "3. Communate of a dialysis patient ocumentation required efore dialysis and upon terview with the Directore 25, 2014, at 8:52 and the facility had because the facility had b	mitted to the facility on ith diagnoses including ure, End Stage Renal orillation. of the June 2014 on Orders revealed edthree times weekly" nunication forms and revealed no ondition of the patient in return for the following 3, 6, 22, and 27, April 3, Dialysis Patient Services, ication is essential to the ication is essential to the return" or of Nursing (DON) on in the DON's office, if failed to provide the ices prior to and after PROVIDED FOR	F 312	DEFICIENCY)	s, duct er ure l for 07/31/14

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PRINTED: 07/02/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(VI) PROMERON PROMERON		OMB NO (
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
\$1\$3.00 m		445373		B. WING			
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	06	/25/2014	
NORTH	SIDE HEALTH CARE	NURSING AND REHABILITATION		202 EAST MTCS ROAD			
			NC	MURFREESBORO, TN 37130			
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		OUT THE THE INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRI DEFICIENCY)	OPRIATE	COMPLETION DATE	
F 312	Continued From page	ge 5	F 31:	2			
į	This REQUIREMEN by:	IT is not met as evidenced	131	Corrective Action:	}		
	Based on review of	Certified Nurse Assistant		I. On 6/25/14, CNA shaved the			
	(CIYA) ASSIONMENTS	Steet checomotion and		sides of the face and chin of the			
	TITLE MEAN, THE ISCHILL	failed to provide grooming ty-one residents reviewed.		female resident #96.	ļ		
i i	The findings included: Resident #100 was admitted to the facility on June 13, 2014, with diagnoses including			2. The DON, ADON, and RNC	1		
1				conducted random audit of female			
				residents on 6/25/14 that revealed	1		
٠			ļ	no other female residents with	i		
į [Diabetes, Dementia, I	Hypertension, and Stroke.	}	unwanted facial hair.			
F	Review of the CNA As	signment Sheet for the Day	1	3. On 6/25/14, Staffing	ĺ	[
1 ~	""" SHO I'IC EVENING	SPHI FOURSISH A.S.	1	Coordinator conducted inservice		ĺ	
	naved daily of 92 dea	lited tacial bair company	}	training for all nursing staff on		i	
"	om female patients	."]	ensuring that female residents are	1	}	
0	bservation on June 2	4, 2014, at 2:30 p.m., in		free from unwanted facial hair.	ĺ	- 1	
1,14	SINDIN WILDOW N	PVPOIDE the social		4 The DOM ADOM TO	j	1	
i i ca	war nam on bom side:	S Of the face and on the	j	4. The DON, ADON, Staffing			
100	int, the hair was appre	oximately 1/4 inch long.	ļ	Coordinator, and/or other designee	1		
Int	erview with resident a	#100 on June 24, 2014, at		will conduct weekly rounds and randomly thereafter to ensure all	1		
2:3	30 p.m., revealed "I d	on't like hair like that."		female residents are free of	-	- 1	
		1	ĺ	unwanted facial hair and will	1		
0.5	servation on June 25	, 2014, at 9:00 a.m. and	1	report findings to the QA&A			
1 44 1	are resid	Phile room rougaland the	- 1	Committee quarterly.	07/3	31/14	
side	es of the face and the	ive the facial hair on the		quality,	1		
Obs	servation with the Din	ector of Nursing (DON)					
; 0110	, or 45 40' 40' 14' St 8:0'	4 a m in regident #400% i	1			1	
facia	al hair on the sides of	ent continued to have the	ļ			}	
chin		the race and on the	1				
Inter	view with the DON, a	at the time of the					
	ervation, confirmed th	e resident had been	j		į	ı	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/02/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 445373 B. WING NAME OF PROVIDER OR SUPPLIER 06/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C 202 EAST MTCS ROAD MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 312 | Continued From page 6 F 312 bathed by the CNA's since Monday morning, removal of facial hair is part of the bathing process, and the resident had facial hair that had not been removed. F 323 483.25(h) FREE OF ACCIDENT F 323 SS=D HAZARDS/SUPERVISION/DEVICES F323 SS=D The facility must ensure that the resident 483.25(h) environment remains as free of accident hazards FREE OF ACCIDENT as is possible; and each resident receives HAZARDS/SUPERVISION/DE adequate supervision and assistance devices to VICES prevent accidents. Requirement: The facility must ensure that the resident environment remains as free of accident hazards as is This REQUIREMENT is not met as evidenced possible; and each resident by: receives adequate supervision and Based on medical record review, review of facility assistance devices to prevent investigation, and interview, the facility failed to accidents. ensure the appropriate lift was used for transfer to prevent accidents for one resident (#28) of Corrective Action: thirty one residents reviewed. 1. On 6/25/14, the Staffing The findings included: Coordinator identified and inserviced CNA #2 and charge Resident #28 was admitted to the facility on nurse on appropriate use of a February 2, 2014, with diagnosis of History of mechanical lift and that all lifts are Falls, Dislocated Shoulder, Acute pain, Contusion only to be used with two persons of Hip, Depressive Disorder, and General Anxiety participating in the transfer. Disorder. The DON conducted visual Medical record review of the Minimum Data Set. audits to ensure the appropriate use dated March 6, 2014, revealed the resident was of a mechanical lift as specified by cognitively intact, required assistance for the manufacturer and that all lifts transfers and ambulation, and had a history of are only to be used with two falls. persons participating in the transfer,

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/02/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445373 B. WING NAME OF PROVIDER OR SUPPLIER 06/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C 202 EAST MTCS ROAD MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 323 Continued From page 7 F 323 Medical record review of a facility investigation 3. On 6/25/14, the Staffing revealed the resident had "...a fall with no injury, Coordinator inserviced nursing on March 25, 2014, at 9:45 p.m., interventions staff on appropriate use of a mechanical lift as specified by the initiated: Use Hoyer lift only for transfers with assist of two, no stand-up lift..." Continued review manufacturer and that all lifts are of the facility investigation revealed "...Certified only to be used with two persons Nursing Assistant (CNA) was transferring resident participating in the transfer. with sit to stand lift (Stand-up lift), resident let go and CNA lowered resident to floor..." 4. The DON, ADON, and/or other designee will conduct weekly Interview with CNA #1 on the 200 hall, on June competency audits/skills check-25, 2014, at 10:20 a.m., revealed the CNA had offs with nursing staff x 60 days been in-serviced on the stand up lift and the and randomly thereafter to ensure Hoyer lift during staff orientation, and at least that policies and manufacturers once per year for all nursing staff. Continued guidelines are followed to ensure interview with the CNA revealed the CNA compliance and will report their demonstrated the procedure for lift use for the findings to the quarterly QA&A 07/31/14 stand-up lift and the Hoyer lift. Further Interview Committee. with the CNA revealed when questioned about the possibility of a resident sliding out of the stand-up lift the CNA stated "...a resident could not slip out of the lift if the seat was properly attached...there should always be two people to assist with transfers with either (stand-up or Hoyer) lift..." Interview with CNA #2 by telephone on June 25, 2014, at 1:20 p.m., revealed the CNA remembered transferring the resident to the bed with the stand-up lift on March 25, 2014, and stated "...was transferring the resident alone when the resident slid out of the lift and was lowered to the floor by holding on to...pants...

Continued interview with the CNA revealed when

questioned about the facilities policy for transferring residents with a stand-up lift, specifically, the number of staff needed for transfers, the CNA confirmed "...two people are required for lift transfers, there was a nurse near

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/02/2014 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 445373 B. WING. 06/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST MTCS ROAD NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 323 | Continued From page 8 F 323 the resident's room, but...told me to go ahead and get the resident in bed, so I attempted the transfer by myself..." Interview with the Director of Nursing (DON) on June 25, 2014, at 1:40 p.m., in the DON's office confirmed the facility did not have a policy for lift use and followed the manufacturers' instructions. Continued interview with the DON confirmed the DON "...the instructions written on the stand-up lift stated under paragraph #3: Whenever possible two caregivers should be present during lifting and transfer." Further interview with teh DON confirmed the facility had failed to ensure the correct lift was used for transfer resulting in a non-injury fall.